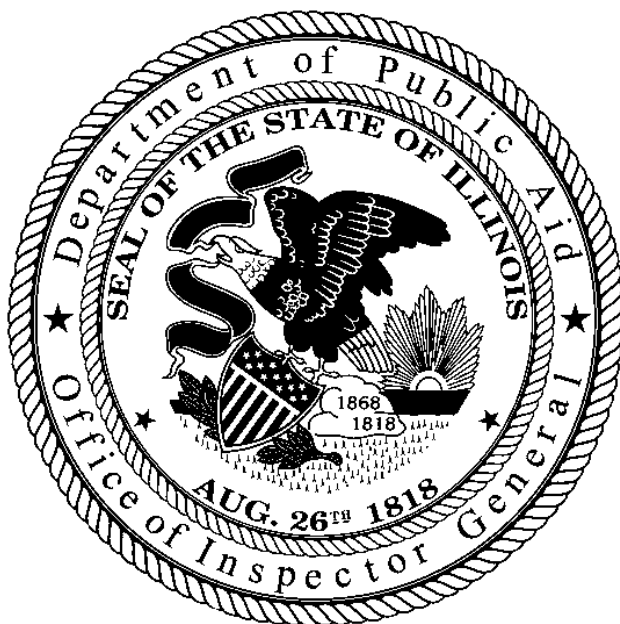


# **Office of Inspector General**

**Illinois Department of Public Aid**

## **2003 Annual Report**



**Rod R. Blagojevich**  
Governor

**Wyona Johnson**  
Acting Inspector General



**Office of Inspector General**  
*Illinois Department of Public Aid*

Rod R. Blagojevich  
*Governor*

Wyona Johnson  
*Acting Inspector General*

March , 2004

**To the Honorable Rod R. Blagojevich, Governor, and Members of the General Assembly:**

I am pleased to present you with the Office of Inspector General's Annual Report for calendar year 2003. This report details activities that have enhanced the integrity of the Illinois Medical Assistance Program and other programs of the Departments of Public Aid and Human Services. This Office has become a national leader in program integrity through the collective efforts of over two hundred staff persons located throughout the state in concert with the commitment and dedication of IDPA and IDHS.

This Office has achieved its goals by maintaining a clear focus on its mission and through successful collaborations with both Departments. We have improved the fiscal integrity of those agencies and increased the safety of their employees and the physical security of our facilities.

As required by Public Act 88-554, this report provides data on payments to medical providers at various earning levels, audits of medical providers, savings generated by the prescription Refill-Too-Soon program, sanctions against providers and investigations.

I hope the OIG's 2003 Annual Report is a valuable resource to you and your staff.

Sincerely,

Wyona Johnson,  
Acting Inspector General

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**Office of Inspector General  
Illinois Department of Public Aid  
Annual Report  
Calendar Year 2003**

***BACKGROUND***

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). The Inspector General is appointed by the Governor and requires confirmation by the State Senate. The OIG operates within DPA but does so independently of the agency director. With the establishment of the State Officials and Employee Ethics Act in December 2003, the Inspector General now reports to the Governor's Executive Inspector General. The OIG is fully committed to ensuring that department programs are administered with the highest degree of integrity.

Prior to 1994, the Division of Program Integrity (DPI) was responsible for many of the duties absorbed by the OIG. The most significant difference between the two entities lies in the OIG's statutory mandate "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct." This directive to first prevent fraud has enabled the OIG to increase its impact on DPA's programs. Nonetheless, DPI built a solid foundation from which the OIG could carry out its mission.

**Scope**

The OIG investigates misconduct in programs administered by DPA and DPA legacy programs in the Department of Human Services (DHS). Since the creation of the OIG, DPA directors and DHS secretaries have routinely recognized the OIG's independence while jointly promoting program integrity and assuring access to financial and medical assistance for persons in need.

Acknowledging its mandate, the OIG has developed and enhanced a broad range of tools and techniques to conduct surveillance, promote prevention and fight fraud and abuse in Medicaid, KidCare, food stamps, cash assistance and child care. The OIG also has enforced the policies of DPA, DHS and the state of Illinois affecting clients, health care providers, vendors and employees.

**Staffing**

OIG staff members include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information system specialists. During 2003, the OIG had an authorized staffing of 236 employees, with 216 employees being on-board at the close of the year. These numbers represent a loss of 21% of OIG staff to early retirement.

**Networking**

The OIG recognizes that effective program integrity rests on a foundation of teamwork within DPA and with the many local, state and federal agencies that share the OIG's goals. Years of collaboration have produced the successes for which all the OIG's program integrity partners can rightfully share credit. OIG staff have been active in the Association of Inspectors General, a national group supporting the work of IG's at state and local levels, and in the federal Centers for

Medicare and Medicaid Services' Medicaid Fraud and Abuse Technical Advisory Group (TAG).

Staff has also been active in the National Welfare Fraud Directors Association, United Council on Welfare Fraud, National Health Care Anti-Fraud Association, National Association of Surveillance Officials, Association of Certified Fraud Examiners, National Internal Affairs Investigators Association and the American Society for Industrial Security.

### **National Recognition**

The program integrity advances realized in 2003 can be traced to the innovative thinking and pioneering efforts of OIG staff. DPA and the OIG have received national recognition for deploying numerous integrity efforts deemed "best practices" in the country in the past several years.

During 2003, Illinois was one of ten states the U.S. General Accounting Office (GAO), the auditing arm of Congress, visited to learn more about its fraud and abuse fighting activities. The study was initiated by United States Senator Charles Grassley, Chairman of the Senate Finance Committee. Representatives from the OIG and the GAO convened October 9-10, 2003, to discuss existing and future initiatives designed to curb fraud, waste and abuse directed at the Illinois Medicaid Program. The OIG provided an organizational overview and an outline of its major responsibilities. Emphasis was focused upon the Office's innovations and activities in fraud prevention and detection, provider audits, quality of care reviews, Surveillance Utilization Review Subsystem (SURS) enhancements, provider sanctions, and recipient restrictions and investigations. In addition, discussion centered around OIG initiatives and its partnerships with other members of the Illinois health care law enforcement community.

Discussion also focused on the OIG's landmark work in Medicaid payment accuracy measurement as the Federal Government is in the process of establishing such a program at the national level. (Illinois was the first state to measure Medicaid payment accuracy in 1998 and has established an ongoing payment accuracy measurement system.) The GAO was specifically interested in Illinois' experiences in developing and implementing its projects. The OIG advised them of its methodology, operational obstacles encountered, financial requirements and technical assistance required to complete the review. In addition, the OIG presented information regarding the data analysis tools and resources it utilizes to identify fraud and abuse in the Illinois Medical Assistance Program.

## ***NEW INTEGRITY ACTIVITIES***

### **Provider Audit Initiatives**

#### ***Record Recoupment***

During 2003, the OIG collected over \$27 million in overpayments. Of the total overpayments collected, over \$25 million was identified through post-payment audits conducted of providers enrolled in the Medicaid Program. This unprecedented level of collections was realized despite the fact that the Bureau of Medicaid Integrity (BMI), the organizational unit of the OIG, which is responsible for conducting provider audits, lost 37 employees, or 27% of its workforce due to the early retirement initiative. It is commendable that BMI staff were able to rise to the challenge and recoup overpayments in such record-breaking fashion during 2003. However, it should be noted that it might be difficult to sustain this level of recoveries in future years without additional staff.

#### ***Desk Audits***

During 2003, the OIG conducted 388 desk audits of Medicaid providers. A desk audit is an in-house review where OIG staff audit a provider's paid Medicaid claims without actually visiting the provider's physical location. By conducting these desk audits, the OIG was able to identify \$1,997,146.00 in overpayments during 2003.

In order to perform these desk audits, auditors utilize computer routines and reports designed to identify various types of potential billing improprieties associated with a provider's paid claims. The types of billing improprieties identified through the desk audits are as follows:

- same lab service was billed by both a physician & another physician
- same lab service was billed by both a physician and an independent laboratory
- same lab service was billed by both a physician and a hospital
- same lab service was billed by both a hospital and another hospital
- same lab service was billed by both a hospital and an independent laboratory
- same lab service was billed by an independent laboratory and another independent laboratory
- transportation service was billed by a transportation provider for a client who was an in-patient in a hospital at the same time
- transportation mileage was billed at full-rate for each client when a lower amount should have been billed because multiple clients were transported in the same vehicle at the same time

#### ***Self Audits***

In 2003, the OIG's Fraud Science Team and Bureau of Medicaid Integrity teamed up to identify \$2.8 million through a self-audit project involving hospital in-patient claims. In a random sample study, the OIG found that claims for DRG 396/986 (Extreme Immaturity or Respiratory Distress Syndrome) with a length of stay of less than 7 days had a billing error rate of over 50%.

A DRG, or Diagnosis Related Group, is a combination of procedures and diagnoses generally associated with the treatment a particular disease or condition. DRGs are used by DPA to pay hospitals prospectively for an entire inpatient stay.

The OIG identified the universe of all such records during a three-year period. Hospitals were provided with an opportunity to conduct a self-audit with OIG staff reviewing the self-audit results. All but one of eighty-nine hospitals selected conducted the self-audit, with the remaining hospital opting to submit their records for departmental review. OIG is now validating a sample to ensure the validity of the self-audits. Over \$1.5 million has been collected to date as a result of this project.

By conducting the self-audit, hospitals and their coding staff have become more aware of this coding problem. The OIG has been able to assist providers in this effort and obtain significant recoupments without sending auditors into the field. As part of our ongoing prevention effort, the OIG is working with the department to ensure that in the future, these types of claims will be suspended for prepayment review. The OIG is now ready to proceed with the next research pilot to determine the extent of billing errors in additional DRG codes.

### **Medi-Medi Project**

The Department of Public Aid's reputation for innovations was one of the factors that led to Illinois being selected as one of five additional states to participate in a joint project with the federal government to pool data, technology and expertise to fight fraud committed against both the Medicaid and Medicare programs in Illinois. This project, called the Medi-Medi project, has been highly successful in the pilot state California and holds promise for Illinois.

DPA and the U.S. Department of Health and Human Services must enter into a Data Match agreement to allow the Medicaid and Medicare data to be combined and used for analysis. The department has executed the agreement and now awaits final federal clearance before the program will begin. This clearance is expected in early calendar year 2004.

OIG's Fraud Science Team plans to modify several of its existing fraud detection routines to incorporate Medicare data not presently available on the department's data warehouse. The goal will be to provide the broadest possible picture of the provider's billing patterns by using significantly more Medicare data than is presently available along with the Medicaid data. For example, the department's time dependent billing routine, a fraud detection oriented computer program that scans millions of claims to identify providers in both programs who bill in excess of 24 hours per day, will be modified to identify billings to both Medicaid and Medicare. This routine will identify providers who submitted claims for payment of services that could not have physically been performed.

The project has other benefits as well. We expect to be able to target more precisely and to identify cross-program vulnerabilities, such as providers incorrectly billing Medicaid first even though Medicaid is the payer of last resort. The project also holds promise as a vehicle for greater federal-state cooperation and coordination for investigations, audits, and case development.

### **Out-of-State Pharmacy Project**

Implemented in December 2003, this project was designed to determine if prescriptions dispensed via mail order by out of state pharmacies were actually received by recipients or if recipients had received medications they did not need. Each of the sixteen out-of-state

pharmacies targeted had paid claims totaling over \$200,000 during the previous twelve months. Recipients receiving home health care services or specific specialty drugs, as well as recipients receiving a small number of prescriptions during the year, were excluded from review. Six months of data is being collected and will be analyzed for appropriate follow-up action.

### **Health Insurance Portability and Accountability Act**

On August 26, 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). This Act includes Administrative Simplification Provisions that apply to the Medicaid program as well as private insurers and Medicare. The impact of HIPAA is far reaching in that it requires Medicaid agencies and the health care community to adopt national standards for electronic transactions, including data elements, standard code sets, unique health identifiers, security safeguards and privacy standards. Two significant areas of HIPAA were implemented across the nation this year that had a direct impact on both state agencies and the health care community:

- Privacy Act - April 13, 2003
- Transaction and Code Sets - October 16, 2003

The Privacy Act had a significant impact on DPA. Major systems changes were required to accept claims in the new standard format. The implementation of the Transaction and Code Sets directed all states to modify their claims processing systems to accept a standardized electronic transaction for all health care claims. The conversion of state-generated procedure codes to a national procedure code set has required substantial programming modifications to the existing Medicaid Management Information System.

To a lesser degree, HIPAA has impacted OIG directly. In responding to data requests from partnering law enforcement entities, OIG has established a mandated data tracking system to account for any data requests containing recipient-specific information. The data requests are maintained in accordance with the HIPAA regulations and will be available for review by entities stipulated in the HIPAA regulations. In addition, the conversion of state-generated procedure codes has resulted in significant modifications to existing fraud and abuse routines.

The availability of new HIPAA data elements will be incorporated into our on-going fraud and abuse research and detection efforts. OIG's ability to track fraudulent providers across the country will be also be enhanced through the creation of a National Provider ID number, which is expected to be implemented in CY 2004.

### **Project CARE III**

The OIG's Bureau of Investigations (BOI) has initiated studies in the past to systematically identify assistance cases with fictitious children and families with children who have medical cards, but appear to have not received any medical services. BOI has found that multiple fictitious children are one of the most lucrative means of welfare fraud because it is extremely difficult to identify non-existent children at the time when a person is applying for assistance.

Through its efforts in Project Children-At-Risk Evaluation (Project CARE), the OIG expanded its ability to predict fraudulent cases based on the fact that the children had received no services.

The third project, Project CARE III, was initiated in November 2002 and completed in July 2003. This project evaluated cases where there were no medical services for a period of 5 years for children between 5 and 13 years of age. A programmatic search of the Medicaid data warehouse found that 121 children met this initial criterion. Eighty-three of the 121 cases were dropped because the cases had either become inactive or the cases were medical only cases, which meant no cash assistance had been rendered. Of the remaining 38 children, six additional children were removed when the cross-match against the Chicago Board of Education database revealed that the children existed in the Chicago Public School system.

BOI investigators completed thorough examinations of the remaining 32 cases. Twenty-one (72%) of the cases investigated revealed some type of discrepancy. The findings included:

- The existence of 4 children could not be verified; therefore, the children were considered fictitious
- Eight children were found to be living out of state
- Six children could not be located (families were not living at the address of record)
- Four children were found to have health insurance through unreported Third Party Liability (TPL)

As a result:

- Cancellation of the case was recommended to the DHS local office in 14 cases.
- Overpayments totaling \$100,407 were discovered in 3 cases, of which \$55,956 was in grants and \$44,451 in food stamps.
- Two spin-off cases generated from the 3 overpayment cases resulted in an additional food stamp overpayment of \$17,985. (The spin-off cases were opened, as the children in question were included in other food stamp households during their period of ineligibility.)
- In 4 cases, insurance coverage through unreported TPL was discovered and reported to the DHS local office. In 3 of these cases, the department paid \$283.51 for medical services. Information was sent to the Bureau of Collections for possible recovery from the responsible third party.

Project CARE III found that non-receipt of medical services by children for an extended period of time is an indicator of potential welfare fraud. The OIG will continue to examine these types of situations as part of its overall integrity efforts.

### **Long Term Care - Asset Discovery Investigations**

As Illinois' senior citizen population increases, the department must take a pro-active and cost-effective approach to control fraud associated with long term care and maintain the integrity of the Illinois Medical Assistance Program. The OIG performed pilot Long Term Care-Asset Discovery Investigations (LTC-ADI) projects in 1996 and again in 1997. The purpose of the investigations was to identify applicants for long-term care assistance who failed to disclose assets or had unallowable asset transfers. The savings associated with the first pilot were \$2.76 for every dollar spent and \$3.32 for every dollar spent during the second pilot.

Recognizing the LTC-ADI pilot projects provided substantial savings, the department sought to find a private vendor to perform these investigations on an ongoing basis. A Request for

Proposals (RFP) was released in late 2002 to competitively procure a private vendor to conduct asset discovery investigations. Working with DHS, a new form to collect additional asset information was added to the intake process for LTC applicants. Local DHS offices would refer applicants for investigation to the OIG, who would in turn forward them to the vendor. The vendor would be responsible for performing field investigations in order to verify applicant information and provide the OIG with a report of findings. The findings would then be used by DHS to determine if the applicant is eligible to receive benefits.

The contract was awarded and the vendor received their first investigation referral on May 19, 2003. Before the vendor completed any investigations, they notified the department that they were not renewing the LTC-ADI contract for FY04. Realizing the importance of these investigations, the Department began the procurement process to obtain another vendor. A new RFP was posted in October 2003 and the department anticipates that the contract will be awarded during the first quarter of 2004.

The OIG, with the support of the department, made the commitment to perform the asset investigations in-house until another vendor could be procured. Temporary accountant staff were hired, and OIG investigators, accountants, and quality control reviewers were reassigned to complete the existing investigations. As of December 31, 2003, the OIG had completed 269 LTC/ADI cases and returned them to the DHS local offices with recommendations. Seventy-four (27.5%) of these completed cases resulted in negative findings, with 30 cases revealing undisclosed assets or unallowable asset transfers, and 44 applicants failing to provide verification or withdrawing their application prior to the completion of the investigation. Analysis of these first 269 completed cases resulted in a projected one year cost savings per case of \$4,605.00.

Based on current projections, 1,000 statewide investigations would realize a savings of \$4.6 million during the first year of the LTC-ADI vendor contract. The department would also realize undocumented saving by avoiding various recoupment processes and costly errors with the initial long-term care application process.

## **ON-GOING INTEGRITY ACTIVITIES**

### **Medicaid Fraud Prevention Executive Workgroup**

In January 1997, the director of the Department of Public Aid approved the creation of the Medicaid Fraud Prevention Executive Workgroup (MFPEW). This workgroup was to be an executive-level oversight committee that ensured that reasonable and prudent measures were being taken to deter and detect fraud and abuse within Medicaid in Illinois.

Today, the workgroup is represented by OIG, Division of Medical Programs, and Medicaid Management Information System (MMIS) management staff with expertise in a broad base of disciplines. These staff members collaborate to develop new fraud prevention methods and ensure MMIS's effectiveness in preventing and detecting improper payments. The workgroup provides a forum to address emerging trends so that potential instances of fraud and abuse can be prevented and detected earlier. MFPEW strengthened the department's fight against fraud by accomplishing the following during CY 2003:

Duplicate Laboratory Routine – The workgroup evaluated pricing logic and department policy to determine the proper way to pay for laboratory services. It was discovered that duplicate payments were made in certain instances. The laboratory editing logic was significantly enhanced to prevent this from occurring in the future. In addition, OIG is in the process of recovering over \$1 million in overpayments paid prior to the implementation of this new logic.

HICL Sequence Numbers–Based on MFPEW's work, the department has implemented an edit to identify and prevent recipients from receiving the same drug in different strengths at the same time, e.g., Prilosec 20 mg and 40 mg capsules. The edit also identifies and prevents recipients from receiving two similar drugs within the same therapeutic drug class at the same time, e.g., Prevacid 30 mg and Prilosec 40 mg capsules. To date, this edit has been implemented in seven drug classes that contain excessive duplication within the same therapeutic class. The department will continue to expand this highly successful edit when newly abused drug classes are identified.

Pharmacy DEA Numbers – It was discovered that certain pharmacies were using a pharmacy DEA number as the prescribing practitioner ID number. This practice is in violation of the Pharmacy Practice Act and Department policy. At MFPEW's direction, an edit has been developed to reject pharmacy claims where a pharmacy's DEA number is submitted in the prescribing practitioner ID field.

### **Fraud Prevention Investigations**

The Fraud Prevention Investigations (FPI) program targets error-prone public assistance applications, which contain suspicious information or meet special criteria for pre-eligibility investigations. The FPI program has provided a seven and one half year estimated average savings of \$12.41 for each \$1.00 spent by the state. FPI has also averaged a 66% denial, reduction or cancellation rate of benefits for 21,802 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings have reached nearly \$49.4 million. The FPI program continues to prove its value to help ensure the integrity

of public assistance programs in Illinois and more important, to increase savings for the taxpayers of Illinois. Generating 4,400 investigations, the program identified 3,352 cases that led to reductions, denials or cancellations in fiscal year 2003. The Bureau of Investigations (BOI) calculated an estimated net savings of more than \$8.1 million for all assistance programs: Temporary Assistance for Needy Families (TANF), Medicaid and Food Stamps. The total gross savings for fiscal year 2003 was \$8,820,707 (\$2.74 million in Medicaid program costs, \$4.33 million in TANF program costs and \$1.74 million in Food Stamp program costs).

### **New Provider Verification**

Another OIG effort to prevent fraud is the New Provider Verification project. Since June 2001, the OIG has conducted pre-enrollment site visits of non-emergency transportation (NET) and Durable Medical Equipment (DME) entities which have applied to become Medicaid providers. The visits were initiated so that the legitimacy of these businesses could be verified prior to their enrollment as providers.

During 2003, the OIG's quality control reviewers performed 196 site visits for 109 non-emergency transportation providers and 87 DME providers. During the visits the reviewers confirmed the business' location and existence, verified information provided on the enrollment application, inquired about ownership information and licenses, checked for Medicare program sanctions, and assessed the business' ability to serve Medicaid clients.

As of December 31, 2003, a total of 546 (332 NET and 214 DME) site visits have been completed. Approximately 10% of each of these groups were not enrolled into the program due to various reasons: incomplete enrollment packages, non-operational businesses, businesses did not respond to contact by the department to establish on-site visit, businesses requested withdrawals from the program or businesses applied for the wrong provider type.

### **New Provider Monitoring**

In December 2001 the OIG began monitoring the billing activity for any NET or DME provider identified through the New Provider Verification enrollment process as having questionable activity (for example, known relationship with a currently terminated or suspended provider). This monitoring is designed to quickly identify potential fraud and abuse in the provider's billing patterns. During 2003, twenty-eight NET and fifteen DME providers were assigned to the OIG Provider Analysis Unit for monitoring to identify unusual payment patterns and trends. Over the last two years, a total of one hundred and thirty-seven providers have been referred for monitoring. As a result of these monitoring activities, four providers have been referred to the Illinois State Police and one provider has been referred for a post-payment audit. In addition, one provider has been referred to the Bureau of Comprehensive Health Services for provider outreach and fifteen providers have been referred back to BMI for a second site-visit or phone contact as a result of no payment or aberrant payment activity.

### **Existing Provider Verification**

OIG utilized its fraud detection routines and field staff to combat fraud and billing errors among current NET providers through the Existing Provider Verification project. Services selected for review were identified from the Fraud Science Team's computerized fraud routines that identified NET services that occurred during an in-patient hospital stay and NET services where

there was no corresponding medical services. Phase I of this project was completed in 2003 and resulted in the identification over of \$380,000 in overpayments, referral of sixteen providers to the Illinois State Police and two providers for ongoing monitoring.

For the in-patient hospital services, the review consisted of hospital visits to obtain medical records for the selected services to verify that the client was in the hospital on the date of the transportation claim. For the transportation with no corresponding medical service, the clients and medical providers were contacted to verify that the services were received by the client, to identify any Medicare or TPL eligibility, or to note any other circumstances that would explain why no corresponding medical claim existed.

The goals of this project were to review establish compliance among NET providers with DPA billing policies and to validate the fraud routines. The OIG plans to implement Phase II of EPV in 2004.

### **KidCare Program Integrity Plan**

During 2003, BMI continued to review the FY02 KidCare active and negative eligibility reviews, which also included satisfaction surveys. The active and negative reviews determined if children were eligible for KidCare, if enrollees accurately reported eligibility information to DPA and if families have been charged correctly for the KidCare Premium program. The reviews also measured the accuracy of payments to KidCare application agents and assessed if DHS/DPA correctly denied applications or canceled children from KidCare. The surveys ascertained enrollees' satisfaction with KidCare, detected any unacceptable practices by KidCare application agents, measured DPA's performance administering KidCare and gathered enrollees' opinions as a way of improving the program and increasing enrollment. BMI expects to publish the KidCare Negative Eligibility and KidCare Active Eligibility Reports during the first quarter of 2004.

In September 2002, a new policy was introduced allowing families with qualifying health insurance to choose between direct state medical coverage (KidCare Share or Premium) or reimbursement for private health insurance (KidCare Rebate). In July 2003, the Bureau of KidCare requested the assistance of BMI in developing and administering a satisfaction survey as the monitoring tool for this new policy. The OIG conducted the KidCare Rebate client satisfaction surveys for the review period of April 2003 through June 2003. A total of 418 surveys were completed. BMI is currently analyzing the results and will publish their findings during the first quarter of 2004.

### **Technology Advances**

OIG continues to utilize the Medicaid Data Warehouse (MDW) to supports functions that are vital to its day-to-day operations. These functions support highly cost effective audits, investigations, and prosecutions of medical providers and recipients.

During 2003, the Provider Claim Detail (PCD) system was implemented in the MDW, replacing the antiquated mainframe computer programs. PCD is a comprehensive operational support system for the OIG audit program and has contributed to the record \$25 million audit collections OIG attained this year. It automated the:

- Selection of paid service universes for audit, and added tremendous flexibility in ways in which audit targeting can be performed
- Storage of universes and samples for each provider in a data mart to facilitate case-specific operational needs (i.e., the establishment and collection of overpayments and the support of any resulting litigation) and performance monitoring, assessment, and improvement efforts

PCD is also used as the core system for a number of special projects and initiatives. It has greatly improved the flexibility and efficiency of OIG's program integrity efforts.

### **Partnerships**

The OIG works in concert with other agencies in accomplishing its mission to prevent and detect fraud and abuse. In 1999 it established the position of Fraud & Abuse Executive to coordinate all federal, state and local law enforcement activity for the Department. To facilitate joint efforts, the OIG and the Illinois State Police Medicaid Fraud Control Unit (MFCU) Director and Chief Prosecutor meet monthly to discuss active cases. In addition to these monthly meetings, the OIG participates in Health Care Fraud Task Forces in all three Federal Districts of Illinois. These task forces are comprised of the U.S. Attorney's Office, Drug Enforcement Agency, Department of Health and Human Services-Office of Inspector General, Illinois State Police Medicaid Fraud Control Unit/Office of the Illinois Attorney General, Federal Bureau of Investigation and the Illinois Department of Public Health. Other participants, such as U.S. Postal Inspectors, the Department of Defense and Internal Revenue Service attend on an as-needed basis. The meetings are extremely productive and consist of such topics as open cases, new initiatives, referrals, operational issues, legislative issues and procedures.

As part of the OIG's involvement with law enforcement, it refers all cases of suspected fraud to the MFCU. OIG also provides Medicaid policy information; witnesses for trial, payment information and coordinate global settlements which result in millions of dollars paid to the Medicaid Program as the result of criminal/civil proceedings and whistle blower lawsuits. The OIG also implements payment withholds, at the request of the MFCU, pursuant to 42 C.F.R. 455.23 in cases of suspected fraud or willful misrepresentation to the Medicaid Program and Public Act 90-725 in the event a medical provider is indicted. As a result of these actions, DPA is currently withholding approximately \$9.3 million as of December 31, 2003.

### **Internal Affairs**

#### ***Internal Investigations***

The Bureau of Internal Affairs has the responsibility to investigate allegations of employee and contractor misconduct. It also oversees the physical security of the agency. In 2003, the following major cases were investigated by internal affairs.

- Auditors discovered that an employee issued \$20,000 in multiple emergency cash and food stamp issuances to a recipient. One employee was responsible for all the emergency issuances. This matter was referred to the Illinois State Police. Internal Affairs assisted the state police with the investigation, which resulted in criminal charges being filed against the employee. The employee pled guilty to felony theft, was sentenced to 24 months probation, and ordered to make restitution in the amount of \$25,000. The employee was subsequently discharged for cause.

- An employee engaged in abuse of time from 1997 until 1999 was involved in overlapping secondary employment which resulted in fraudulent payroll or travel reimbursements in the amount of \$21,390.83. Prosecution was declined; however, the employee was discharged for cause. An involuntary offset was established through the Illinois Comptroller's office to recoup the \$21,390.83.
- An employee misrepresented financial status to qualify for subsidized childcare benefits by not reporting state income. Since 1996, the employee received \$40,000 in subsidized childcare benefits. The employee resigned and later pled guilty to State Benefits Fraud. The employee was sentenced to 30 months probation, fined \$1,000, and ordered to make restitution at the rate of \$25 per month.
- An employee of a childcare provider network was suspected of updating a relative's childcare case with false information. The employee was discharged. The investigation determined that the fraudulent activities were more widespread than originally reported. The employee was later indicted for theft in excess of \$100,000.00 and state benefit fraud.
- An employee used Amtrak train services for state travel, but claimed personal automobile mileage reimbursement instead. As a result, the employee obtained \$4227.35 more reimbursement than entitled. The employee resigned to Internal Affairs investigators. The case was referred for prosecution by the Illinois State Police, but due to a defense motion on a legal technicality, charges were subsequently dismissed.
- An employee of a contractor was involved in stalking. The person had also falsified the employment application by omitting a conviction to an offense associated with the victim of the stalking. The contractor removed his employee from IDPA.
- An employee was receiving benefits from both the state of North Carolina and Illinois. The case was referred for prosecution and the employee was convicted of State Benefits Fraud and sentenced to one-year conditional discharge and made restitution of \$2,800. The employee was discharged for cause.
- An employee had sexual relations with a client in his/her assigned caseload. When confronted with the evidence, the employee resigned.
- An employee sent a harassing email to an 11 year old who was the daughter of the employee's spouse. The employee used a fictitious third party Internet service provider account while utilizing IDPA's Internet resources from a workstation. The employee was discharged as a probationary employee with no appeal rights.
- An employee falsified records and engaged in time abuse by claiming overtime then leaving earlier than what was represented on the payroll records. When confronted with the evidence, the employee resigned.
- A former employee of a childcare provider network diverted childcare payments to

individuals who did not provide childcare. The person fraudulently authorized \$107,531.32 in childcare payments using the United States Postal Service. The person was indicted and convicted in federal court on five counts of mail fraud and sentenced to 14 months in prison and ordered to make restitution.

- An employee logged an excessive amount of hours on the Internet viewing hard-core pornographic material. When confronted with the evidence obtained from the OIG's computer forensic examination of the hard drive, the employee resigned.

### ***Security and Employee Safety***

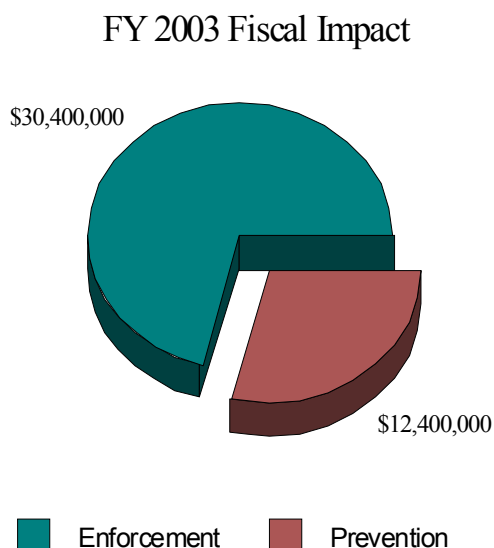
The Hirsch access control system is an ongoing effort to provide a safe and secure environment for clients, staff, contractors and visitors. It tracks and reports employee building access and movement to controlled areas within buildings. The system has allowed us to lock non-public locations to prevent access from unwanted visitors.

OIG's security coordinator continued to monitor building security guard contracts and performance and assess reported incidents of physical threats by other employees, clients, non-custodial parents and other civilians against employees and clients.

OIG continues to maintain the electronic photo ID badges for all DPA employees and contractors utilizing the enhanced Hirsch security system software. Approximately 3,150 badges are currently in use.

### ***FISCAL IMPACT***

In fiscal year 2003, the OIG realized a savings of approximately \$42.8 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings. This savings was almost double the OIG FY2003 budget of \$22.7 million.



#### Prevention Activities:

Recipient Restrictions  
 Fraud Prevention Investigations  
 FS Disqualifications/Cost Avoidance  
 Medicaid Fraud Prevention Executive Workgroup  
 Fraud Science Team  
 Payment Accuracy Review Measurement

#### Enforcement Activities:

Provider Audits  
 Client Fraud Investigations  
 HMO Marketing Misconduct  
 Provider Sanctions  
 Medicaid Quality Control Reviews  
 Food Stamp Disqualifications  
 Physician Peer Reviews  
 Internal Investigations  
 Fraud Science Team

### ***CONCLUSION***

In the nine years since its creation, the OIG has aggressively moved forward on numerous fronts to expand the depth and breadth of its program integrity mission. By relying on the hard work of OIG staff, the close cooperation with DPA, state and federal agencies, and the deployment of new technology and scientific methods, the standard for program integrity has been raised in Medicaid and other social services. The dividends have been better prevention methods, faster and broader detection tools and increased financial recoveries. Through its efforts, the OIG has succeeded in raising awareness of the importance of program integrity among clients, providers and the citizens of Illinois.

OIG Published Reports

<b>Title</b>	<b>Date</b>	<b>Description</b>
<i>Fraud Prevention Investigations:FY02 Cost Benefit Analysis</i>	September 2002	Identified \$9.8 million in net savings with a benefit of \$12.31 for every dollar spent.
<i>Fraud Prevention Investigations:FY01 Cost Benefit Analysis</i>	September 2001	Identified an estimated \$8.6 million in annual net savings for 2001, boosting the total estimated savings to \$31.4 million since FPI began in 1996.
<i>Child Support Emergency Checks</i>	June 2001	An OIG-initiated study determined that 99.9% percent of the nearly \$14 million in emergency child support checks were either legitimate or never cashed. Of the 0.1% of the checks that remain unresolved, four have been confirmed as fraudulent.
<i>Fraud Prevention Investigations:FY00 Cost/Benefit Analysis</i>	November 2000	The program was expanded to all 23 local DHS offices in Cook County. It identified an estimated \$8.7 million in net savings, with a benefit of \$11.60 for every dollar spent. Since it's inception in 1996, the program's estimated net savings have been nearly \$23 million.
<i>Fraud Prevention Investigations:FY99 Cost/Benefit Analysis</i>	March 2000	Identified \$4.5 million in annual net savings with a benefit of \$12.12 for every dollar spent.
<i>Death Notification Project:Identifying the Cause of Delay in Notification</i>	February 2000	Evaluated whether nursing homes or DHS local offices are responsible for case cancellations due to death. The workgroup found that neither party is completely accountable, and made recommendations for improvement in the notification process. The workgroup also proposed increased monitoring of the 26 nursing home's identified as having the highest incidences of overpayments due to late notice of death.
<i>Non-Emergency Medical Transportation Reviews: Focusing on Compliance</i>	December 1999	A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation.

Title	Date	Description
<i>Project Care: Exploring Methods to Proactively Identify Fraud</i>	December 1999	Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.
<i>Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments</i>	December 1999	Recommended methods by which non-institutional post mortem payments could be identified more quickly.
<i>Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21<sup>st</sup> Century</i>	September 1999	Verified the cost-effectiveness of searching for assets of LTC applicants.
<i>Recipient Services Verification Project: RSVP II-Home Health Care</i>	August 1999	Confirmed receipt by clients of home health care services.
<i>Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues</i>	June 1999	Validated the effectiveness of the project's error-prone criteria and processes.
<i>Fraud Prevention Investigations: FY98 Cost/Benefit Analysis</i>	December 1998	Identified an estimated \$4 million in net savings with a benefit of \$14.25 for every dollar spent.
<i>Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices</i>	October 1998	Examined weaknesses in the security of the agencies and proposes several recommendations for improvement.
<i>Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement</i>	August 1998	First ever such study in the nation. Identified that the department accurately expends 95.28%, plus or minus 2.31%, of total dollars paid.
<i>Medicaid Client Satisfaction Survey: October 1996-September 1997</i>	July 1998	Measured client satisfaction with quality and access in both fee-for-service and managed care.
<i>Postmortem Medicaid Payments: Identifying Inappropriate Provider Payments on Behalf of Deceased Clients</i>	April 1998	Confirmed that LTC client cases were not being canceled timely resulting in overpayments to nursing homes and made several recommendations for improvement.
<i>Fraud Prevention Investigations: FY97 Cost/Benefit Analysis</i>	February 1998	Identified an estimated \$3.63 million in net savings with a benefit of \$13.02 for every dollar spent.
<i>Medical Transportation: A Study of Payment and Monitoring Practices</i>	December 1997	Identified policy changes and monitoring strategies.

Title	Date	Description
<i>Funeral and Burial: A Review of Claims Processing Issues</i>	October 1997	Examined policies and procedures of the Department of Human Services in paying for client funeral and burial and made recommendations for improvement.
<i>Maintaining A Safe Workplace: Best Practices in Violence Prevention</i>	June 1997	Identified best practices available to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors.
<i>Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings</i>	May 1997	Recommended a thorough assessment of software systems for prospective review of billings, which have the potential to save the State millions.
<i>Fraud Science Team Development Initiative Proposal</i>	April 1997	Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments.
<i>Medicaid Client Satisfaction Survey: April 1996-September 1996</i>	April 1997	Measured client satisfaction with quality and access in both fee-for-services and managed care.
<i>Prior Approval Study</i>	May 1996	Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature.
<i>Clozaril Report</i>	February 1996	Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement.
<i>Hospital Inpatient Project Summary Report</i>	April 1994	Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.

Most of these reports are available on our web site at [www.state.il.us/agency/oig](http://www.state.il.us/agency/oig). They can also be obtained by contacting the Inspector Generals office, Illinois Department of Public Aid at 217-524-7658.

**STATISTICAL TABLES****Audits of Medical Providers**

The OIG initiates medical audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Medical audits generally cover an 18-month period and are conducted on institutional and non-institutional providers. When a provider is selected for an audit, the provider is contacted, and records are reviewed onsite by the audit staff. Providers with identified overpayments are asked to either repay the liability, present documentation to dispute the findings or request an administrative hearing. Audits are considered completed upon receipt of the provider's payment, a negotiated settlement or the DPA Director's final decision. The provider may repay the department by check or by a credit against billings, in either monthly installments or a single payment. Because providers are allowed to make payments in installments, collections vary, and the amount reported will often cover audits closed in previous quarters. Collections generally result from audits completed in prior periods.

**Collection of Overpayments  
CY 2003**

Audits	797
Collections	\$27,588,214.53

**Collection of Provider and/or Client Restitutions**

Monies collected are from fraud convictions, provider criminal investigations and civil settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or by installments and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

**Collection of Provider and/or Client Restitutions  
CY 2003**

Amount Collected	\$403,253.09
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**Refill Too Soon**

This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid prescription claim. The estimated savings represents the maximum amount the department could save as a result of RTS edits. Once payment for a prescription is rejected, the prescription is likely to be resubmitted later, after the first prescription expires. The estimated savings shown in this table represents the value of all rejected prescriptions, but the true savings are potentially less.

**Refill Too Soon Program  
CY 2003**

Total Number of Scripts	34,318,309
Amount Payable	\$1,706,413,975
Scripts Not Subject to RTS	93,729
Amount Payable	\$6,016,035
Scripts Subject to RTS	34,224,580
Amount Payable	\$1,700,397,940
Number of Scripts	1,480,416
Estimated Savings	\$83,922,642

**Provider Sanctions**

The OIG acts as the department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

**Provider Sanctions  
CY 2003**

Hearings Initiated	
Termination	15
Suspension	1
Denied Application	7
Recoupment	20
Termination/Recoupment	7
Decertification	6
LTC/Hospital Assessment	0
Child Support Sanctions	93
Total	149
Providers Sanctioned	
Termination	10
Voluntary Withdrawal	3
Suspension	9
Denied Application	13
Recoupment	27
Termination/Recoupment	4
Decertification	0
Child Support Sanctions	80
Negotiated Settlements	5
Other P.A. 88-554 Sanctions	0
Total	151
Cost Savings	\$606,952.85
Cost Avoidance	\$15,325.15

**Client Eligibility Investigations**

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public aid. Investigation results are provided to caseworkers to calculate the overpayments. Cases with large overpayments or aggravated circumstances are prepared for criminal prosecution and presented to a state's attorney or a U.S. attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits. Clients who intentionally violate Food Stamp Program regulations are disqualified for 12 months for the first violation, 24 months for the second violation, permanently for a third violation and 10 years for receiving duplicate assistance.

**Client Eligibility Investigations  
CY 2003**

Investigations Completed	1,171
Estimated Overpayments	
Grant and Food Stamps	\$2,249,378
Medical*	\$137,841
Types of Allegations	
Employment	16%
Family Composition	26%
Residence	9%
Interstate Benefits	3%
Other Income	9%
Assets	6%
Multiple Grants	1%
Other	30%
Total	100%
Food Stamp Disqualification	783

\*NOTE: Includes Medical overpayments from Client Eligibility Investigations and Medical Investigations

**Child Care Investigations**

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning childcare. Client fraud occurs when earnings from providing childcare are not reported, when childcare needs are misrepresented or when a client steals the childcare payment. Vendor fraud occurs when claims are made for care not provided or for care at inappropriate rates. The results are provided to DHS' Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney, a U.S. attorney or the Illinois Department of Human Services, Bureau of Collections for possible civil litigation.

**Child Care Investigations  
CY 2003**

Investigations Completed	52
Overpayment Identified	\$408,194
Prosecution	
Accepted for Prosecution	5
Overpayment on Cases	\$131,571
Convictions	1
Restitutions Ordered	\$27,203

**Client Prosecutions**

The OIG conducts welfare fraud investigations involving large financial losses. Substantiated cases are referred to a state's attorney or U.S. Attorney for criminal prosecution, or to the Illinois Department of Human Services, Bureau of Collections for possible civil litigation. These cases may involve multiple cases with false identities, failure to report income, long-term fraud involving the circumstances of the client and other instances that have resulted in large overpayments to undeserving individuals.

**Client Prosecutions  
CY 2003**

Prosecution	
Accepted for Prosecution	64
Overpayment on Cases	\$419,334
Convictions	37
Restitutions Ordered	\$221,434
Acquittals	0

**Medical Abuse Investigations**

The OIG investigates allegations of abuse of the Medical Assistance Program by clients. Abusive clients may be placed in the Recipient Restriction Program (RRP). The restriction process begins with a computer selection of clients whose medical services indicate abuse. After reviews by staff and medical consultants, clients are restricted to a primary care physician, pharmacy, or clinic for 12 months on the first offense and 24 months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider, except in emergencies. Abusive clients may choose to enroll in an HMO as an alternative to RRP.

**Medical Abuse Investigations  
CY 2003**

Medical Over utilization	
12 Months	
Recipient Reviews Completed	1,934
Recipients Restricted for 12 months as of 12/14/02	529
Recipient Restrictions Added	381
*Recipient Restrictions Released and Canceled	492
Recipients Restricted for 12 months as of 12/12/03	418
24 Months	
Recipient Re-evaluations Completed	763
Recipients Restricted for 24 months as of 12/14/02	148
Recipient Restrictions Added	155
*Recipient Restrictions Released and Canceled	64
Recipients Restricted for 24 months as of 12/12/03	296
Recipients opting for an HMO instead of restriction as of 1/1/03	59
Recipients opting for an HMO instead of restriction as of 12/31/03	31
Cost Avoidance for 2003	\$499,439

\*Releases are a result of: cancellation of Medicaid eligibility, death of recipient, opting to select an HMO or program compliance.

**HMO Marketer Investigations**

The OIG monitors marketing practices to ensure clients have the opportunity to make an informed choice when enrolling with an HMO and to prevent HMOs from avoiding the sickest clients. The DPA's Bureau of Managed Care maintains a toll-free complaint hotline from which the majority of referrals are received.

Marketers who have engaged in misconduct or fraudulent marketing practices are removed from the DPA's HMO Marketer Register, which lists HMO marketers from whom the DPA will accept enrollments.

**HMO Marketer Investigations  
CY 2003**

Types of Allegations	
Fraud	7
Misrepresentation	0
Unethical Practices/Other	0
Total	7
Findings	
Substantiated	3
Unsubstantiated	3
Unable to Determine	1
Total	7

**Internal Investigations**

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its security oversight. The investigators are not sworn, do not carry firearms and do not have arrest powers. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses and contract violations. Investigations often reveal violations of several work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension or a reprimand.

**Internal Investigations  
CY 2003**

Investigations Completed	
Substantiated	145
Unsubstantiated	56
Total	201
Types of Allegations	
Non-Criminal (Work Rules)	
Discourteous Treatment of Others	13.5%
Failing to Follow Instructions	1.0%
Negligence in Performing Duties	12.2%
Engaging in Business with a Client	.2%
Incompatible Outside Interests	3.3%
Sexual Harassment	.9%
Release of Confidential Agency Records	1.8%
Misuse of Computer System	5.1%
Falsification of Records	2.9%
Other Work Rule Violations	17.8%
Work Place Violence	9.5%
Criminal (Work Rules)	
Misappropriations of State Funds	.6%
Attempted Fraud or Theft	2.2%
Commission of or Conviction of a Crime	1.3%
Other	.4%
Public Assistance Fraud Offenses ILCS Chapter 305	1.3%
Criminal Code Offenses ILCS Chapter 720	20.0%
Contract Violations, Security Issues	3.5%
Special Projects, Background Checks, Assist other Agencies	2.5%
Total	100.0%
Misconduct Cited	
Employees	57
Vendors	6
Total	63
Resolutions	
Discharged	16
Resigned	12
Suspensions	24
Other, such as reprimands	26
Administrative Action Pending at Year End	8
No Action Taken	7
Total	93

**APPENDIX - AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION**

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed at [www.state.il.us/agency/oig](http://www.state.il.us/agency/oig) under the heading of calendar year 2003 Annual Report/Data. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type and will be available in early 2004.

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*[www.state.il.us/agency/oig](http://www.state.il.us/agency/oig)*

*Welfare/Medical Fraud Hotline 1-800-252-8903 TTY 1-800-447-6404*